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The Relative Value of Certain Obstetrical Operations

(Embryotomy, Cesarean Section, Symphysiotomy)

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THE

RELATIVE VALUE OF CERTAIN OBSTETRICAL OPERATIONS.[1]

(EMBRYOTOMY, CESAREAN SECTION, SYMPHYSIOTOMY.)

When requested by the Committee of Arrangements to organize an obstetric discussion for this meeting, I could think of no topic more timely, more worthy of judicial estimation, than that of the limitations of embryotomy, Cesarean section, and symphysiotomy. It is a marked sign of progress in obstetrics that such a discussion is possible at all, of rapid progress within a comparatively short time. Memory need not be taxed much beyond a decade to find practical condemnation of the Cesarean section, except in instances where the birth canal was from one or another cause so blocked as to forbid even an embryotomy; and it is only within the past few months that an operation over one hundred years old has seen the dawn of a new birth full of the promise of a green and worthy old age. I deem myself most fortunate, therefore, in having secured the co-operation of distinguished colleagues whose aim it will be to place before you an impartial estimate of the limitations of these obstetric operations, and my peculiar province will be to consider, in brief, certain of the causes which have rendered possible the *elective* surgery which is surely gaining foothold in obstetrics, with the result that two lives are to-day often saved where formerly one was certainly lost and a second greatly imperilled if not also lost.

It is unnecessary to dwell at any length on the predominant

[1] Remarks in opening the obstetric discussion before the meeting of the State Medical Society, Albany, February 7th, 1893.

influence which has been exerted on obstetrics by antisepsis and asepsis—synonyms for scrupulous cleanliness. Without this factor even embryotomy carried risk to the woman, and the recognition of its stringent necessity enables us to reject embryotomy and to elect either the Cesarean section or symphysiotomy. Equally uncalled for at this time is more than passing reference to the uterine suture which so effectually guards against gaping of the wound and thus removes at once a further source of danger from the Cesarean section. I would dwell more particularly, in general terms, on *the one* great question which renders elective surgery in obstetrics at all possible—accurate pelvimetry —and incidentally I would voice the thought which to-day is uppermost in the mind of every physician: Have we indeed reached the day when destruction of fetal life is not our bounden duty except where maternal life is otherwise greatly jeopardized?

The tendency of the times—and we are to be congratulated that we live in such an age—is to make of obstetrics an exact science. No longer should the guesswork, the trusting-to-nature obstetrics of the past be tolerated. As responsible men, to whom is entrusted the welfare of two lives, it is a duty not to be shirked, and inexcusable if shirked, to familiarize ourselves from the start with the configuration of the pelvis of every woman who entrusts herself to our care during the supremest of her trials; and not alone this, but it is also our duty to determine as accurately as possible the capacity of the fetus for entering the world with least risk to its mother and to itself. The statement is a most humiliating one to make, but most of us have been in the past, many of us are still, recreant to this duty. How many physicians examine their patients before the onset of labor? How many possess a pelvimeter, or use one if they do? And yet in any case the physician may be called upon to elect one or another obstetric operation—the induction of premature labor, the forceps, version, symphysiotomy, the Cesarean section, even sometimes embryotomy. Exactitude of diagnosis is deemed requisite in other branches of medicine; why should not the same be incumbent on the physician who ventures to care for the pregnant woman? The issue is the same—well-being or ill-being, life or death—nay, it is greater, for not alone is the woman's welfare at stake, but also that of the child. And yet, again, outside of maternity hospitals, it is far too much the routine to take

for granted that all is right and to dismiss the gravida from further consideration, aside from casual examination of the urine, until, summoned to her bedside, she is found in labor. Even then it is the exception, rather than the rule, for an examination to be made extending beyond the recognition of the presenting part. All this is reprehensible; all this is doomed to radical change. It needs not my words to remind you that the forceps has its indications and limitations, as also version, the Cesarean section, symphysiotomy, and embryotomy. The time to determine both these indications and these limitations in a given case is before the advent of labor, and the only way we can secure the necessary knowledge is through external pelvimetry, associated, if need be, with internal. Not alone is the type of pelvis to be determined—whether flat-rachitic, generally contracted, etc.—but also, at or near term, is it essential to estimate, by the rather crude methods, I must confess, at our disposal, the probable size of the fetus which must pass the pelvic canal. With such information at his disposal, the physician is not likely, together with his consultants, to attempt to drag through the pelvis by his forceps a fetus which can only be made to fit the pelvis, if at all, at the expense of its life as well as at the expense of the integrity of essential parts of the woman's organism. Neither is he going to continue such fruitless efforts until, the fetus being dead and the woman exhausted if not nearly dead, he concludes that the single possible method of extraction is by an embryotomy. Very crude obstetrics is this, and yet what man present has not witnessed it? The long and short of the whole matter is this: The exact methods which prevail in maternity hospitals must be transported into the private practice even of those whose lot it is to labor amongst the very poor. The dispensary physician, as well as his more favored brother whose calling it is to soothe the pangs of maternity amongst the very rich, should be in a position, from knowledge acquired by careful pelvimetry, to elect at the proper time one or another of the operations the limitations of which are shortly to be considered. This can only be done, obviously, where the acquired knowledge plainly teaches that one or another of the lesser operations (forceps and version) will not avail. The patient must not be made the subject of experiment. The Cesarean section, in particular, is likely to fail in its twofold aim (the saving of mother and child) if it be not resorted to until forceps, and possibly version, have been repeatedly tested. To

place the matter in its extremest light—*the physician must be prepared to elect even embryotomy;* for if the living fetus must be sacrificed at all, far better is it that this should be accomplished in a timely fashion rather than when maternal exhaustion is imminent or present. In the latter event the woman may be sacrificed as well.

Two of the operations which will shortly be considered have been devised and have been perfected with the end in view of avoiding mutilation of the living child. The accumulated data of the past teach us very clearly the chances in a given case, through resort to one or another operation, of saving the child without subjecting the woman to extra special risk. Whilst I am not in sympathy with those who claim that under no circumstances should the living fetus be sacrificed, I am prepared to contend that the exceptions to this rule are to-day very few. The technique of the Cesarean section has reached such perfection that in more than one maternity hospital it has over and again been proved that the risk the woman is subjected to is no greater than that which embryotomy entails. Indeed, in one of the maternities with which I am connected the mortality rate, during the same interval, from Cesarean section was *nil*, whilst from embryotomy it was one hundred per cent. As for the recently revived operation of symphysiotomy, the record is as yet a clean one. Is it any wonder, then, that physicians in general are beginning to query as to whether, other things equal, it is a part of their professional duty to take the life of the child when a duly elected alternate operation will save both the woman and the child. This is a question neither of religion nor of foolish sentimentality; it is not a question of the value of greater or lesser life. In the light of present knowledge it becomes a question of doing our best by two lives instead of simply ignoring one.

I would ask, then, that the limitations of these operations be considered purely from a scientific standpoint. In practice such of late years has been the rule in maternities, and the written record is one of which no physician need be ashamed. When the time is ripe, as it shortly must be, for the application of similar reasoning and rules to our private clientèle, I see no reason to doubt but that the record will be the same. The nature of these limitations it is now the privilege of those who follow me to tersely state.

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